



# STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower

The Governor Nelson A. Rockefeller Empire State Plaza

Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.  
*Commissioner*

Dennis P. Whalen  
*Executive Deputy Commissioner*

October 25, 2002

Ms. Cheryl Tarver  
Division of Integrated Health Systems  
Family and Children's Health Program Group, CMSO  
Centers for Medicare and Medicaid Services  
7500 Security Blvd., Mail Stop S2-01-16  
Baltimore, Maryland 21244-1850

Dear Ms. Tarver:

This is to advise you that New York State Department of Health accepts CMS's approval of the extension of our Section 1115 waiver, the Partnership Plan, as outlined in Thomas Scully's letter of September 27, 2002 and as modified through Terms and Conditions changes contained herein. These changes to Attachments J and N of the Terms and Conditions result from discussions we have had over the past few weeks. The Department recognizes that although we have reached general agreement on revised Terms and Conditions, these revisions still require formal CMS approval. The Department's acceptance of CMS's approval of the extension is contingent upon reaching agreement with CMS on language amending Attachments J and N of the waiver Terms and Conditions.

We look forward to finalizing the Terms and Conditions language with you.

Sincerely,

Kathleen Shure, Director  
Office of Managed Care

Attachments

cc: Mike Melendez, Region II

*The Community Health Care Conversion Demonstration Project*

The State shall take necessary actions to implement the Community Health Care Conversion Demonstration Project (CHCCDP) to enable eligible hospitals to undertake health service delivery and work force restructuring activities. The extension approval includes a phase-out of new Federal funds for CHCCDP over a two-year period.

1. The State will

- (a) claim Title XIX Federal matching for State payments made on or after the date of approval (July 15, 1997) through the:

Professional Education Pool (PEP )  
Child Health Insurance Program (CHIP)  
New York Small Business Health Insurance Partnership Program  
New York Individual Voucher Program  
New York Individual Pilot Program  
Catastrophic Insurance Program  
Clinic, Laboratory and Ambulatory Surgery Indigent Care Distributions  
Elderly Pharmaceutical Insurance Coverage Program  
AIDS Drug Assistance Program

- (b) and, additionally, upon 30 days notice to CMS, claim Title XIX Federal matching for State payments made on or after April 1, 2003 through the:

School-based Health Centers Pool Distributions  
Article 17 Indigent Health Care Assistance Program

- (c) permit the Federal share of the matching payments to be allocated to hospitals participating in CHCCDP.

The State asserts it does not require amendments to State statutes to claim Title XIX Federal matching on the above programs. CMS agrees to make Title XIX Federal matching available for the above programs without change to existing State processes for making program payments.

CMS agrees the distributions from the State (and its local jurisdictions for expenditures claimed for the Article 17 Indigent Health Care Assistance Program) for programs listed above in item 1(a) and (b) may be claimed in whole or in part. CMS further agrees that the claim for FFP may shift among facilities, increase or decrease upon a reconciliation of projected facility specific DSH ceilings to actual Medicaid and uninsured losses for a given period.

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2. Funding for CHCCDP will be from Federal Financial Participation made available to the State after it funds (with 100percent State dollars) the programs identified in paragraph 1.a and 1.b. above, provided, however, that expenditures made on and after April 1, 2003 for the Professional Education Pool may be made upon receipt of Federal Financial Participation authorized pursuant to this paragraph.
  - a. Federal matching funds for these programs combined shall not exceed ~~\$500~~\$250 million per year for the initial demonstration period and the first year of the extension period and ~~\$200~~\$100 million for the second year of the extension period (based on the date in which the State submits program costs to CMS for match), subject to the State's ability to initiate corresponding annual claims, within all applicable Federal payment limitations, for programs listed in Paragraph 1.a and 1.b above. Such amount includes \$1.25 billion for the initial demonstration, and \$250 million and \$100 million in new funds, respectively for the first two years of the extension period. If Federal action or the application of Federal laws or regulations adversely affect the State's ability to generate the required claim for these programs (\$500 million in each year of the initial demonstration period, \$500 million in the first year of the extension and \$200 million in the second year of the extension), and there is mutual agreement that the claim cannot be achieved, acceptable alternative claims within all applicable Federal payments limitations must be mutually identified to maintain the annual level of funding pursuant to this paragraph. With these Federal funds, the State shall make payments to hospitals participating in CHCCDP. Solely from the Federal funds available, total payments for CHCCDP shall be equal to \$250 million a year for each year of the initial demonstration, \$250 million for the first year of the extension and \$100 million for the second year of the extension..
  - b. An allowance for CHIP shall be included in the without waiver baseline, only to the extent that CHIP is eligible for Federal match as a cost not otherwise matchable and the Federal matching dollars are used for the purpose of funding CHCCDP (see also c, below). The State understands that, aside from CHIP, none of the sources of matching funds for CHCCDP may be included in the without waiver baseline.
  - c. To the extent that the State elects to use CHIP expenditures as the State match for Federal funds made available through Federal legislation (or for other Federal programs), these expenditures will not be eligible for Federal Medicaid match under the 1115 demonstration, and consequently will not be available to fund CHCCDP. In such instance and to the extent necessary, an acceptable alternative claim within all applicable Federal payment limitations must be mutually identified to maintain the annual level of funding authorized pursuant to this paragraph.
3. Federal matching funds for the programs identified in paragraph 1(a) and (b) above will be available to the State in any given year only if the State demonstrates it has legislative authority to spend these additional monies solely for awards under CHCCDP.

4. The award of FFP for expenditures associated with the programs identified in 1(a) and (b) in no way results in these programs being an entitlement under the State's Medicaid program or altering the benefit package under State law for these programs.

5. During the initial demonstration period, payments under CHCCDP will only be provided to hospitals that meet the criteria specified in 5a, and shall be limited to health service delivery and work force restructuring activities in conformity with the requirements outlined in item 9.

- a. Eligibility for distribution of funds will be limited to public and voluntary hospitals in New York State that have at least **20** percent of total discharges from Medicaid and self-pay; have at least 5,000 total discharges per year; and certify that they will provide medically necessary care, available to privately-insured patients at that institution, to all indigent patients (including Medicaid patients who are not enrolled in an MCO, to the extent these services are covered under Title XIX) presenting themselves to the hospital for services.

For the first year of the demonstration, all eligible hospitals who meet the criteria defined above shall receive their funding allocation in accordance with the provisions in item 6. In subsequent years of CHCCDP, funding allocations shall be limited to hospitals that are participating in The Partnership Plan program, either as hospital-based MCOs, and/or subcontractors to Partnership Plan MCOs. Eligible hospitals that have not entered into contractual arrangements to serve partnership plan enrollees and wish to continue to receive CHCCDP funding, may appeal to the Commissioner of the New York State Department of Health. If the Commissioner determines that a hospital's rationale for not having a contract is legitimate, an exemption to this requirement may be granted.

- b. Funds will be allocated to hospitals according to the following formula: Each hospital will receive a percentage of the funds determined by the ratio of the hospital's weighted Medicaid plus self-pay discharges to the total weighted Medicaid plus self-pay discharges of all participating hospitals. The weighting factor for each hospital will be the percentage of that hospital's discharges that are Medicaid and self-pay.
  - c. In award year one the formulas in items 5a and 5b will be based on New York State Institutional Cost Report data for 1995. For subsequent award years during the initial demonstration, the formulas in items 5a and 5b will be based on New York State Institutional Cost Report data for the period two years preceding the award year.
  - d. **CMS** and the State will work together to develop a mutually agreed upon allocation methodology based upon Medicaid and indigent outpatient visits that will modify the methodology described in b above. This methodology will be
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used for fund allocation for the second and subsequent years of the initial demonstration.

6. For the initial demonstration period, all upstate hospitals eligible for CHCCDP funding and participation in Phase 1 of mandatory enrollment under the Partnership Plan shall receive the full allocated amount in the first year, depending on the availability of funds, based on the formula prescribed in 5b above once CMS has approved mandatory enrollment for Phase 1. At that time, all other eligible hospitals, including hospitals in New York City, shall receive 15 percent of their first year allocation, depending upon the availability of funds. Such eligible hospitals, depending on the availability of funds, shall receive an additional 15 percent once CMS has approved a date certain agreeable to the Commissioner of Health for mandatory enrollment for Phase 2, with the balance to be disbursed once Phase II mandatory enrollment commences. Receipt of funding in any year of the initial demonstration is contingent on the eligible hospitals submitting an application to the State on an annual basis that details the restructuring goals of the upcoming year and accomplishments over the previous year, if applicable, including the activities outlined in item 10 below. Upon review of the applications, if the State determines that the hospitals have met their prior year restructuring goals and have appropriate goals for upcoming periods, hospitals will receive the full annual allocated amount, depending on available funds. Any funds not allocated to eligible hospitals, in whole or in part, as a result of failing to meet these requirements shall be reallocated to other eligible hospitals by the Commissioner pursuant to the formula described in 5b and 5c above. Funds distributed to eligible hospitals may be recouped by the Commissioner from such hospitals upon an audit finding that the expenditure of funds was not in keeping with the approved application for meeting CHCCDP goals established for the initial demonstration period.
  7. For extension periods, payments under CHCCDP will be provided to hospitals, based on formulas or applications established by the State, for payment of graduate medical education, health facility restructuring, and health workforce retraining, recruitment, and retention costs which are otherwise not reimbursed by Medicaid or other payors of hospital services.
  - 8. All Title XIX payments made directly by the State to hospitals will be subject to the OBRA 1993 DSH limits. State CHCCDP awards to facilities are not Title XIX payments.
  9. Within 60 days of approval of necessary State legislation, the State shall submit an amendment to the operational protocol for the Partnership Plan that describes in detail how the State will operate and monitor CHCCDP for the initial demonstration period, including (but not limited to) the following: the component of the State responsible for administering CHCCDP; the model application form for hospitals; the allocation of funds to each hospital; the specific funding mechanism; the review and approval process to determine how hospitals will utilize the allocated funds; and the audit methodology to assure that funds are expended appropriately. Within 60 days of Federal approval of final Terms and Conditions to extend CHCCDP, the State shall submit further amendments to
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the operations protocols for The Partnership Plan to provide a description of State operational and monitoring procedures related to programs referenced in paragraph 7 above.

10. In order to expand primary care capacity in New York and to accommodate the restructuring in health facilities serving the poor, New York's safety net infrastructure must be further strengthened. To accomplish this, in reviewing any required applications, the State will encourage hospitals to incorporate the following types of linkages into their restructuring plans: enhanced linkages to existing article 28 diagnostic and treatment centers, pursuant to the State definition; establishment of new, hospital affiliated article 28 facilities (or subparts of facilities, including RHCs and FQHCs); expansion or enhancement of existing affiliated article 44 preferred health services providers, or the creation of new, hospital affiliated article 44 providers; enhanced linkages with local health departments; establishment of new, hospital affiliated individual or physician primary care group practices in Federally-recognized medically underserved areas and health professional shortage areas.
11. If any Federal legislation or regulatory revisions affects aggregate Statewide disproportionate share limitations, upper payment limits, or aggregate or per-capita Medical Assistance payments limits, the State shall submit to CMS a methodology for coming into compliance with the law. (See Section II.B. of these terms and conditions.)  
  
CMS shall give deference in such methodology to State-proposed actions that give priority to preserving the eligibility status and benefits of recipients participating in the New York State Partnership Plan. Such methodology shall be in response to any Federal payment limitation resulting from this waiver or later Federal statutory or regulatory revisions, including but not limited to: facility specific disproportionate share distribution limits, aggregate statewide disproportionate share limitations, upper payment limits, and aggregate or per capita Medical Assistance payment limits. Funding levels for any program initiated under the terms and conditions of this waiver may be adjusted, in whole or in part, to fully accommodate the aforementioned Federal payment limitations and would be given favorable consideration for approval if the State can sufficiently demonstrate that access to needed services by State Medicaid recipients is not diminished.
12. The first phase of mandatory enrollment under The Partnership Plan will not be implemented until necessary State legislation has been enacted by the State Legislature to appropriate funds for CHCCDP consistent with the aforementioned terms and conditions.
13. FFP is available for administrative costs associated with the operation, monitoring, and auditing of CHCCDP.

*Family Planning Expansions***I. Applicability**

This attachment applies to the provision of the following family planning services:

- A. 24 months of extended family planning services provided to Partnership Plan enrollees who lose eligibility 60 days post-partum; and
- B. family planning services provided to women and men with net incomes at or below 200 percent of the Federal Poverty Level (FPL)

**11. Special Terms for Population Served Under Section I.A above**

- A. The State will allow women who are eligible for extended family planning services the opportunity to continue receiving family planning services through the family planning extension, or apply for FHPlus. ~~If a woman wants to waive her right to an eligibility determination for FHPlus, the State will ensure that she has all the information she needs, both written and oral, to make a fully informed choice.~~

**111. Special Terms for Population Served Under Section I.B above**

- A. The State will allow applicants the opportunity to apply for family planning benefits through the family planning expansion, or apply for Medicaid (full coverage package) and/or FHPlus. If an applicant wants to waive his/her right to an eligibility determination for Medicaid (full coverage package) or FHPlus, the State will ensure that applicants have all the information they need, both written and oral, to make a fully informed choice.
- B. The State will allow applicants who are enrolled in SCHIP the opportunity to also enroll in the family planning expansion. For those services provided to individuals enrolled in both the SCHIP program and the family planning expansion, the State will claim the SCHIP matching rate for family planning services covered by the SCHIP State Plan. On an annual basis, the State projects that approximately 625 children enrolled in SCHIP will be likely to use family planning services through the family planning expansion program (which equals 5 percent of the 12,500 children enrolled in SCHIP who may use family planning services.) The State agrees to use these projections to develop a methodology to ensure that duplicate payments are not made on the part of the Federal government and that the State claims Federal payment at the appropriate FMAP. ~~make an estimated off-line adjustment to ensure that the Federal payment for a CHIP enrollee seeking services through the family planning expansion is netted to reflect no FFP for the Medicaid portion of the claims. In the event that a CHIP enrollee accesses family planning services through the family planning expansion program instead of the CHIP program, those services will not be claimed at the 90 percent FFP rate, but rather the CHIP matching rate. Further, the State agrees to develop a post-payment audit methodology to verify the accuracy of the estimates designed to avoid duplicate payments and apply the appropriate FMAP percentage, and make corresponding adjustment. CMS requires that the State have this audit process in place within a year of the approval of this amendment. Within one year of the approval of this amendment,~~

the State shall include this methodology in the operational protocol which is subject to CMS review and approval.

- ~~C. The State will allow applicants who are enrolled in Medicaid (full coverage package) or FHP Plus the opportunity to also enroll in the family planning expansion. In this case the State will project the number of individuals enrolled in either Medicaid (full coverage package) or FHP Plus on an annual basis that are likely to also apply for and use family planning services through the family planning expansion program. The State agrees to use these projections to develop a methodology to ensure that duplicate payments are not made on the part of the Federal government. Further, the State agrees to develop a post-payment audit methodology to verify the accuracy of the estimates designed to avoid duplicate payments and make corresponding adjustments. CMS requires that the State have this audit process in place within a year of the approval of this amendment.~~

#### IV. General Financial Requirements

In addition to the family planning financial requirements set forth below, the State shall comply with the financial requirements as outlined in Attachment A of these Special Terms and Conditions, current CMS reporting guidelines and directives, and pertinent guidelines described in CMS's Financial Management Review Guide for Family Planning Services (revised in February 2002). The State must comply with these requirements and the following financial reporting procedures.

- A. All expenditures for the family planning expansions will be differentiated from other Medicaid expenditures by separately identifying them on a CMS-64.9 WAIVER and/or CMS-64.9P WAIVER with the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).
- B. CMS will provide FFP at the appropriate administrative matching rate for administrative expenditures associated with services rendered for the family planning expansions. Administrative costs will not be included in budget neutrality; however, the State must separately track and report administrative costs attributable to the family planning expansions on the Form CMS-64.10 Waiver and/or 64.10P Waiver. Administrative expenditures matched at 90 percent FFP have been limited to those rare instances where expenditures are attributable to **an** integrated package of "offering, ~~arranging and furnishing~~ of family planning services."
- C. Outreach performed by the Medicaid agency or other entities under contract to the Medicaid agency will be claimed at the administrative match of 50 percent FFP.
- D. **FFP** for services (including prescriptions) provided to women and men receiving family planning services will be available at the following rates:
1. For services whose primary purpose is family planning (determining family size) and which are provided in a family planning setting, FFP will be available at the 90 percent matching rate. Procedure codes for office visits, laboratory and other tests and procedures must carry a diagnosis code that specifically identifies them as a family planning service. Procedures and services eligible for the 90 percent match are described in CMS's Financial Management Review Guide for Family Planning Services (revised in February 2002).

~~2. For medical diagnosis or treatment services that are provided ancillary to a family planning service in a family planning setting—specifically, follow-up diagnostic tests, treatment for sexually transmitted diseases (STDs) and complication services—and which carry a diagnosis code which indicates that they are related to a family planning service, FFP will be available at the regular FMAP rate. “Family planning setting” excludes inpatient hospital.~~

2. FFP will not be available for the costs of any services, items or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them.

43. For example, in the instance of testing for an STD as part of a family planning visit, the match rate would be 90 percent. The match rate for the subsequent treatment would be the regular FMAP rate. For testing or treatment not associated with a family planning visit, no match would be available.

## V. General Reporting Requirements

- A. As part of the State's quarterly, annual and final progress reports on the demonstration, the State will provide a narrative of progress, including the number of individuals receiving family planning services, broken out by services provided in Sections I.A and I.B.
- B. On a yearly basis, the State will provide CMS with the average cost of a Medicaid-funded birth. The cost of a birth includes prenatal, delivery and pregnancy-related services and services to infants from birth through age five for the child. (The services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy.)
- C. The State will submit to CMS, on a yearly basis, the number of actual births that occur to demonstration participants.

## VI. Other Requirements

- A. The state shall facilitate access to primary care services for individuals receiving family **planning** services. The state shall submit to **CMS** a copy of the written materials that ~~are distributed to the family planning participants as soon as~~ they are available. The **written materials must** explain to the participants how they ~~can access primary care~~ services.